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ABSTRACT

Factors which influence the federal government's policy toward health care include cost, technology, social values, federalism, interest group politics, increased federal involvement, and the current utilitarian attitude toward research. The interaction of these factors results in a complex process of policy formation. For example, when the national government intervenes in health care issues it must consider the conflicting interests: if cigarette smoking is a determinant of health, should the government subsidize tobacco farms? Further, federalism (the sharing of power among different levels of government) creates a disjunction between administrative and regulatory responsibilities. Conflict arises over whether national health insurance should be administered by states or by a centralized federal bureaucracy, or whether health controls should be nationally uniform, tailored to individual characteristics of states. Pressure from interest groups such as medical organizations, the insurance industry, and consumer groups results in incremental rather than comprehensive policy making. Increased federal involvement in physician training and research and through Medicare and Medicaid programs has created a growing demand for policy analysis. Finally, the current attitude toward research as supporting prevailing beliefs rather than providing an informed appraisal of issues creates only partial knowledge, from which policy must be formed. (KC)

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HEALTH POLICY FORMULATION ON A FEDERAL LEVEL, PROCESS AND SUBSTANCE

by

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SP 014 132

HEALTH SCIENCES DEPARTMENT
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ABSTRACT

. Policy development is an important aspect of an expanding health care field. However, the rapidly changing environmental context makes effective policy development and implementation more difficult. Technological advances in medicine, access to this medical technology, cost factors for medical care, increased demand for available limited medical supply and services, and changing inputs and ecological contexts, all require functional policy and flexible planning to achieve policy objectives. These multi-variables also require a more thorough understanding of the process itself.

There is a wide range of material on the substance of policy, but somewhat limited resources on policy making process. This paper will explore socio-political dimensions of the ecological context significant for understanding this policy making process in American health care.

I. COST

The cost of medical care in the United States is an important input which leads to the shaping of federal health policy. With governmental involvement in health care, it has become a partner in the health operation, and costs must be figured not only for the individual but aggregate costs for society as well. Costs have risen dramatically. The nation's medical care bill grew tenfold from 27 billion to 275 billion between 1960 and 1981, and the average cost of hospital stay increased in the 1971-81 period from $670 to $2,119 (Stevens, 1). Currently, almost one dollar in every 10 generated by the American economy is spent on medical care, compared to a lower percentage of 1 in 20 only 20 years ago, and the Federal medical budget for medicare and medicaid is 9% of the Federal budget. In addition to the dollar costs, in 1981 there were approximately 7 million people employed in the medical industry, further accentuating the economic importance of policy formulation in health care.

Health policy is an output of a broad system of interacting variables, (See Appendix I), among which is the culture context. **Also, there are different types of policy issues and analytical questions pertaining to these issues (See Appendix 2).**

II. THE AMERICAN CULTURAL CONTEXT - INDUSTRIALISM AND POST-INDUSTRIALISM

The American cultural context and the syndrome of values related to industrial and post-industrial society are part of the context relevant for understanding health policy in the United States. We have been moving away from ideology in dealing with social problems, to reform through some type of managerial and professional intervention, an end to ideology (Daniel Bell). This focus results from management needs of our economy which faces problems of administration not ideology. Basic issues remain, but we are now faced with public policy needs of coping with our technological stage of development in many areas including social security, medical care

for the aged, support for an expanding system of health, the maintenance of full employment, the conservation of resources, and the renewal of our decaying cities.

Although we haven't solved the problems of industrial society, we have already entered the period and problems of post-industrial society, characterized by health policy issues related to affluence, urbanization, infant mortality rates of 10-15 per 1000, high female labor force participation, low fertility, and long life expectancy (Fuchs, 154). We are in the process of becoming a "Third Wave" society with a new energy base of photo-electric cells, and renewable multi-energy sources, a science and technology base of space science, nucleonics, genetic engineering, demassified media, individualized and customized production, domination by service (tertiary) industries, iron color working forces (robiotics), multi-type families and institutions, an information network wired for instant relays, an educational system of electronic learning, and lifelong learning capacity and ideology (Toffler). The coal mine, steel mill and assembly line workshops of an early industrial society have been replaced to a high degree by the hospital, the classroom and the shopping center, activity sites of the new society. Significant decline in the importance of non-governmental, family and religious

institutions originally helped the market economy function. Without these supports institutions, a market economy does not function in the same way.

In this emerging context, medical and health care need redefinition. Income has become less important as one of a number of determinants of health which include health resources, medical technology, education, and other variables. There has been a marked decline of the income affect on health, and a correlation between income and life expectancy has become very low. An increase in medical resources, given a reasonable quantity as a base, does not have much effect on health. However education, the number of years of schooling, consistently appears as a significant correlant of good health, regardless of the way health is measured (e.g.,mortality, morbidity, symptoms, or subjective education), and regardless of the unit of observation (e.g., individuals, city or state averages) (Fuchs, 156-9).

III. INDIVIDUAL OR SOCIAL RESPONSIBILITY FOR HEALTH CARE, A POLICY QUESTION

The national government faces a dual pressure when it intervenes on policy issues in the health field. In intervening, it must take into account both the economic needs of the health industry, and the organized demand of the public, needs and demands which do not necessarily coincide. Hospitals, the heart of the health care industry need to have people consuming more of their goods and services in order to survive economically with a lower unit cost, and often require governmental help to increase the level of consumption (Renaud, 112). On popular consensus issues such as universal health insurance, both consumer and provider groups can be satisfied with the same policy and therefore it can be an easy win for the government. This does not require taking any particular unpopular stand. Yet, if the work factor is a producer of illness in workers, the government taking a preventive stance may find itself at odds with the profit making motive of the factory owners. How can it resolve the conflicting interests of those who benefit from a clean environment with those who benefit from a dirty environment? If work satisfaction is a crucial determinant in longevity, as indicated in the fifteen year governmental study, Work in America (U.S. Surgeon General). Is intervention justified to improve environmental conditions, and the work factor and hence longevity? If cigarette smoking is a determinant of health, should government subsidize tobacco growing and that type of farming?

The response of the modern medicine is to avoid the issue, and not deal effectively with environmental stimuli and insults which are the prime cause of disease. It focuses on the medical and technological questions of curing disease rather than on the social and political questions of preventing disease. In fact over medicalization itself produces new diseases. (Renaud, 113)

The modern government intervenes in medical areas only to the extent that these do not jeopardize the economic targets of capital growth and expansion, structural contraints which limit the responsiveness to health issues. There are "diseases of civilization," heart and nervous disorders, some forms of cancer, and diabetes which are not simply age-related degenerative processes, but are consequences of changes in behavior associated with economic development, and of industrial induced changes of the natural environment (Renaud, 106-114). One should look at illness in an ecological context with socio-political focus on environmental causation rather than succumbing to blaming the victims. Medicine, hesitates to call health-compromising processes, such as arterial degeneration, raising blood pressure and tendency toward diabetes, as "diseases" because these are associated with a way of life our value system accepts as normal (Renaud, 108).

Culturally, we validate these environmental causes by focusing on the business of curing and rehabilitation rather than prevention.

The view of health and illness as the realm of individual responsibility modifies health needs and legitimates this modification. It transforms social problems into individual problems, handled by selling commodities of health services, and engineered to remove society as a responsible element in health.

IV. THE AMERICAN POLITICAL CONTEXT

A. FEDERALISM

Understanding the policy making process in the United States, requires a grasp of the Federal system. It is primarily a system of checks and balances in which interest balances interest, and faction balances faction. Fear of a strong central government was responsible initially for the unsuccessful centrifigal Articles of Confederation, and later for this ingenious "balancing" act of Federalism. Under Federalism, power is shared between different branches of government, and by different levels of government. To accumulate sufficient power to shape policy, interest groups must join, and in the process, balance and modify their policy objectives. It is a process which political scientist James McGregor Burns has called the "Deadlock of Democracy" (Burns).

A process which reduces the possibility of any one faction or interest group dominating policy formulation. Until the Reagan administration's unusual successes in 1981 budget and tax matters, it was assumed that the process seriously limited policy-making options by any faction or special interest.

Shifting emphasis between central and local authority characterize the American political rhythm. A key political tactic is to court the majority by inveighing against the encroachments of central power, the current "New Federalism" emphasis. Political pulsation in American history has been marked by upsurges in Federal strength followed by periods of lethargy and drift. Kennedy's "New Frontier," the civil rights movement, and the urban crisis produced the Great Society of 1964-68, a period of brief expansion of the Federal role. Weakness in the federal government brings on crises which are met in part by a resurgence of the Federal power. We are now going through a period of declining central power, which in turn will probably cause a crisis requiring more extensive central power (Brown, Washington Report..., 825).

What is the relevance of Federalism for health policy. It has resulted in a disjunction between administrative and

regulatory responsibilities and accountability (Vladeck, 522). In three particular health policy areas, medical cutbacks, provider licensure and health planning, the federal structure has defined the ground rules and types of conflict that ensue in health policy issues, and has influenced process, and consequently policy. The Federal structure has affected transitional questions of policy design (Vladeck, 523): National health insurance - should it be administered by the states or by a centralized federal bureaucracy? How much flexibility should states be permitted in classifying inpatient facilities reimburseable with federal funds? Cost control activities - should they be nationally uniform, or tailored to the individual characteristics of the states through state administration? These and other similar questions revolve around this Federalism, centralization vs. decentralization theme.

This fragmented federal rather than unitary organizational structure, results in incremental rather than comprehensive planning. The rational decision-making model might look well philosophically, but it doesn't work in a system where the payoff comes from wheeling and dealing, and negotiation with multi-interest groups. This incrementalism results in discontinuous and to a degree inconsistent policies in American health care. Often various laws and programs administered by different

sections of the Department of Health and Human Services (DHSS)reflect this fragmentation. Each section is responsible for the effective administration of its program, not for the development or implementation of a coherent, aggregate national health policy. Medicare, administered by one branch of the DHHS, pays higher fees to urban physicians than to those practicing in rural areas while, at the same time, other sections administer programs designed to induce physicians to move to rural areas. Some divisions of DHHS focus on the importance of prevention, while others are not permitted to pay for preventive services (Fein, 364-366).

V. INTEREST GROUP POLITICS HEALTH POLICY FORMULATION

The fragmentation and inconsistency of policy reflect the basing of decisions on interest group, incremental politics. The pluralistic input of our society results in a mediating advocacy environment for health policy by labor, consumer groups, medical organizations, insurance industry, hospital associations, and federal agency bureaucracy, representing parochial legislators and different governmental layers. All interest groups are supposed to be involved in some way, and dependent on the issue, some are accorded veto privileges.

There is coalition building among interest groups involved in health policy formulation, at different levels. At the Federal level we have the bureaucracy, Office of Management and Budget, and policy advisors in the executive.

Among the political parties, there are committees and Congressional regional groups. The providers have their coalitions among the Department of Health and Human Services and State and local officials. Local interest build their coalitions and are generally active at the point of implementation. An incremental approach to policy formulation enables negotiated trade-offs between interest groups on quality, access, and economy, to expand benefits, dramatically, or incrementally, and to accompany them by small increments of planning, regulation, and control (Brown, 57-58).

In the Federal structure, the fragmented separation and division of power encourages interest groups to seek out multiple access points open to lobbying and pressuring. Diffusion of power and responsibility, plus minimal accountability and multi-access points, lead investigators to wonder who, if anyone, is really in charge (Dahl) instead of the conspiratorial view of a power elite (Mills). The concept

of power as diffused and fragmented is a valuable concept for understanding the incremental nature of the policy - making process in the United States.

In our Federal system, in the Executive branch, the President has a broad national constituency. Theoretically, he is less available to factions and limited interest groups unless he is committed to more ideological position. On the other hand in the Legislative branch, Congressional representatives represent narrower constituencies ranging from the broad constituency of Senators to the highly parochial roles and constituencies of Representatives who survive by representing their districts. It is through Congressional committees that interest groups are able to secure significant input and or veto in the policy-making arena. Theoretically, rational evidence should be basis of policy decisions on the Federal level. In a practical sense, health care policy questions in America are not resolved by the weight of rational evidence and comprehensive decision-making but by the competition and interaction of multi-interest groups.

The competition of these interest groups result in an incremental rather than a comprehensive approach to establishing health policy. Because of this, the basic problem in policy-making is not one of information but resolving the conflicting and competing interests

among groups which dig in further when fund cuts are threatened (Alford, 75). The function of research is practical rather than "pure" and theoretical. Currently, cost containment has become a major objective. In this "fixed sum" type issue, interests of one group are promoted only by a corresponding loss to another group, and this fact results in tension and conflict in the health policy arena (Mechanic, 1).

Incremental policy development is the name of the game, but it is doubtful that the ad hoc measures of incrementalism can deal with the cost problems of a $200 billion health industry without some comprehensive policy. It is probable that the problem is of such a magnitude that small steps will not produce small results, but have no real effect at all (Fein, 366).

There are both formal and informal levels of interaction and decision-making for policy-making. The informal relationships are more difficult to clarify because insiders are not likely to reveal the bare bones of policy-making to outsiders. Also, negotiations and settlements which take place on an informal level leave little recorded material for understanding the process and the wheeling and dealing involved.

The diverse constituencies and interest groups in the health of health care field pose problems both for management which must balance the constituencies to arrive at a needed level of support, and legislators who must decide between competing interests and pressures to develop acceptable legislative proposals.

The balancing interests must take into account diverse groups in the health service arena. These include: interest groups related to the particular phase of health service, e.g. research, regulation, education, medical and hospital care; interest groups related to job categories performing the services, e.g., physicians, dentists, engineers, biologists, nurses, dieticians, chemists, laboratory technicians and numerous other professional and subprofessional groups; interest groups affected by the services provided, e.g. distributors, processors of drugs and foods, nursing homes, medical schools, proprietary and voluntary hospitals, universities, health and welfare associations, some religious groups on certain issues and public consumers; and interest groups of a public agency nature, e.g., welfare, sanitation, education, housing, land use, water supply and education (Kaufman, 35).

The interest groups in turn have their own constituencies which are cultivated, and counted upon for needed support when showdown time comes on policy. Effective administrators of interest groups can call upon their constituencies to exert pressure on behalf of that interest group. Reciprocity requires these administrators to pay back their constituencies and support them when their interests are on the line. This leads to interlocking alliances of interest group operations for which change intervention is very difficult and threatening. The balance of these forces reinforces the incremental rather than comprehensive change strategies operational in the American political arena.

One key issue over which conflicting interests jocky for position in health policy formulation is the question of cost, particularly as it pertains to cost control and expenditure for services. Consumers are interested in cutting costs as long as someone else's "ox is being gored," but if they are ill or in need of medical services they feel that no effort should be spared. Few consumers consider the care they need as unworthy, but often view the availability of this type of care to others as unnecessary expenditure (Mechanic, 3).

Physicians are a significant interest group with a strong political position because of support by patients for their "ally" doctors. Consumers concern about physician fees is minimal because such fees are generally no more than one-fifth of total expenditures, and the total cost might well be covered by third-party payments. Most of the cost of medical services are not for the physician's fees but for the services recommended on the basis of his decision. It is difficult for a consumer to judge if the service recommended is really appropriate or needed, or expect physicians to hold back on their recommendations if third party payments make a thorough treatment possible. By recommending a full range of tests, physicians covered by third party payments, can avoid malpractice suits, without evident cost to the consumer. Consumer and medical interest groups therefore do little about cost containment, because they do not see their direct interests at stake.

Another interest group, government itself, also becomes involved in the policy arena through the various and often competing governmental agencies. Although government is interested in aggregate costs as a basis for policy-making, cost containment and control often impact government agencies differently resulting in their support or opposition for certain policies. The issue of home care shows the differential

views of government agencies when it comes to policy-formulation. Home care for the elderly as opposed to hospital or nursing home care, evidently reduces aggregate costs for elderly care. But, health departments, nursing homes using Title XIX, and health coordinating agencies will take positions regarding home care related to their particular interest rather than to the aggregate of elderly client interest. Plugging one hole and meeting the needs of one interest group does not result in plugging other holes and meeting the needs of all interest groups. It might merely displace pressure on that agency which has the least leverage on a particular issue (Mechanic, 6).

Reflecting the concern of interest groups for their own rather than aggregate interest is the Medicaid situation. Cutbacks in Medicaid eligibility may actually be more expensive for aggregate costs, through of particular benefit to an interest group. Older people might have to rely on more expensive hospital care when blocked out of nursing homes. Dumping mental patients on communities, might transfer costs but does not result in lower aggregate costs. There is need for a more systematic planning, but interest groups will of necessity protect their own survival and interests.

Other interest groups, like the American Medical Association (AMA) have access to organization, money, professional legitimacy, purpose,

leade hip roles and geographical distribution. Interest groups such as the AMA, before 1965, were able to use their resources and pressures on Congress rather than the president. Under Harry Truman, the AMA effectively blocked National Health Insurance, and under Truman and Eisenhower, the growth of programs was in non-controversial areas and by congressional rather than by presidential initiative. This pattern of AMA power over congress and its functioning as a veto group was broken by the election of John Kennedy and the expansion of presidential power under Lyndon Johnson. Particularly under Johnson, the executive assumed leadership on health issues, and Medicare legislation was passed.

VI. INCREASED FEDERAL INVOLVEMENT IN HEALTH POLICY

There has been increased Federal involvement in the health care society. Until recently, the health area was not considered a valid area for government involvement, and meaningful intervention was blocked by veto groups, primarily the AMA. After W. W. II, the primary focus of acceptable federal intervention was in allocating research funds for biomedical areas and involvement in hospital construction. Since 1965, there has been a dramatic expansion with Federal government involvement in Medicare and Medicaid payments.

Under the Medicare program, the Federal government has emerged as a full partner in the purchasing of medical care, and has thus become concerned and involved in doing something regarding costs and quality. Under President Richard Nixon, the government took the lead in having Health Maintenance Organizations change the health delivery system, and under President Gerald Ford, the executive pressured for loading more of health costs on employers (Brown,49).

In addition, since 1965, the Federal government has been involved in sponsoring new organizational forms of health care delivery (neighborhood health centers and health maintenance organizations), planning and regulation of health systems agencies, Professional Standard Review Organizations (PSRO's), and some rate setting.

Federal government involvement includes monitoring quality and appropriateness of physician care through PSRO's, and dealing with maldistribution by specialty and place through the Health Professions Educational Assistance Act. Through the Health Planning and Resources Development Act of 1974, state legislative involvement is required; third party reimbursement is affected by federally promoted HMO's; and planning coordination and regulation are facilitated by the federal government's establishing health

systems agencies on an area-wide basis (Brown, 46).

The Federal government is engaged in four prime activity areas which provide a degree of cohesion and consistency for policy. These are: general support for providers and an increase in health resources supply (this is accomplished through the Hill Burton Act Program of health facility renovation and construction); programs to train physicians and allied medical manpower, and National Institutes of health biomedical research; support for new forms of health care delivery (in particular neighborhood health centers and HMO's) support for regulation and planning of health care institutions and services (this includes PSROs, rate setting efforts and health systems agencies), and support to medically indigent and elderly poor in paying their medical bills (through the Medicaid and Medicare programs)

Three major consequences of Federal government involvement in the post-Medicare period are: the demoting of the AMA and its medical allies from "veto" to "interest" groups and the consequent Federal government claim of vital interest; the reduction of partisan differences between Democrats and Republicans with both groups strongly supporting cost/benefit analyses; and a growing demand for policy analysis and new ideas to rationalize diverse interest groups and operations in health care.

VII. THE USES OF KNOWLEDGE AND RESEARCH IN PLANNING AND PUBLIC HEALTH POLICY FORMULATION

What is the function of knowledge and information in the policy making process? The rationalist view holds that a knowledge base is important and should serve as a basic instrument for change intervention. This instrumental view of knowledge has little applicability in a pluralistic society of incremental decision-making. The other view is that knowledge and information have an indirect rather than a direct impact to influence the general conceptual frame used in decision-making; that knowledge informs and shapes debate and general policy directions although it is not instrumental. In actuality, research on health service impacts the health policy arena through its general influences on private and public actors in the industry and through uses made of it by public officials (Bice, 175).

This general influence view is a more accurate description of the actual use of knowledge in our pragmatic American society. Uses of knowledge in policy formulation can be particularly significant when the knowledge comes from research sources, structured into areas of interest and expertise which parallel those of policy-making departments of the government. Policy research centers organized as parallel shadows to existing government agencies can therefore expect their research knowledge to be most functional despite the incremental policy limits of a pluralistic society (Bice, 180). Additional

factors which affect uses of knowledge for policy formulation include: the historical context, the organizational structure, the degree to which the decision-making is centralized, the situational factor, and the characteristic of individuals and organizations that implement that policy (Bice, 183-185).

Prior to the 1960's, decentralization characterized public health service policies. The principal policy instruments were subsidy and direct service programs for developing health services and their distribution. Traditional grants-in-aid programs, which assigned primary administrative responsibilities to states and lower levels of government, were the prime channels for Federal policy and action. Federally supported research was used to develop knowledge for use in improving the performance of private organizations and agencies of state and local governments.

In the 1960's, legislation created a considerably more centralized policy context. Federal administrative roles were enlarged by service programs established under the War on Poverty, and the Medicare and Medicaid programs. Newer needs for information applied primarily to programs, administered directly by mission-oriented federal agencies, focusing on the operations and performance of varieties of service delivery and financing aspects of federal programs.

By the end of the 1960s, policy consensus shifted from one of subsidies and growth to a focus on controls and "cost containing" a shrinking system. Centralized regulatory programs mandated and operated by governments were expressions of public policy. The decentralized and multi-layered structures through which policy is now implemented do not embody a clear national consensus and allow several opportunities for deflection and dilution of cost-containment objectives.

In the early 1960's health service research was given an organizational focus of the National Center for Health Services Research and Development. This agency sponsored a wide variety of research and helped to provide a great latitude and wide differentiation in the health research field. At the present time, this differentiation has continued and government agencies and private associations have enlarged staffs involved in mission oriented research. As a result of this mission orientation rather than pure research policy, debate may ensue as confrontation among interested parties, each armed with partial and self-serving knowledge rather than on the basis of pure research (Bice, 186).

The special function of social and economic research in policy-making is essentially instrumental and mission oriented; post-hoc in regard to policy rather than ad-hoc. Research generally follows the public policy consensus and provides the support framework for a policy of prevailing beliefs and consensus more than an informed appraisal of issues and alternatives (Anderson, 46).

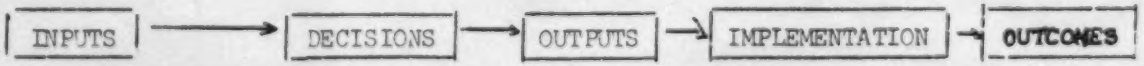
SUMMARY

There are many factors influencing health policy formulation in the U.S. related to the broader environmental context. These factors include cost, technological stage of our society, values of individualism, the American Federal system, interest group politics, an increased Federal involvement and a utilitarian function of research. To understand the end product of policy, it is important to consider the process and substance of interaction by the multi-variables involved.

A SYSTEMS APPROACH FOR UNDERSTANDING HEALTH POLICY ON A FEDERAL LEVEL - Stambler

A. INPUTS AND A2	MEDIATING ADVOCACY ENVIRONMENT	B. DECISION MAKING ENVIRONMENT	C. TYPES OF POLICY OUTPUTS AFFECTING COST/QUALITY/ ACCESS	D. POLICY IMPLEMENTATION	E. POLICY OUTCOMES
1. Demand/Supply Gaps	1. Interest groups: Labor, medical, consumer organizations, insurance industry hospital associations	1. Executive branch	Distribution, redistribution, or regulation	1. Federal level	1. Evaluation on basis of cost/ quality/ access
2. Costs	2. Federal Agency Bureaucracy	2. Legislative branch		2. State & Local levels	2. Feedback to "input" category
3. Historical context	3. Federal legislative bureaucracy	3. Judicial branch		3. Health agencies	
4. Post-Industrial Society	4. State and Local government	4. Political parties		4. Information and directive system	
5. Values: cultural, symbolic function of health, views on govt. role, planning vs. market		5. Existing policy context		5. Regulation	
6. Situational and transient factors				6. Competition	
7. Perception of services resources: Access/costs/quality					
8. Political factors (pluralism)					
9. Research and Knowledge base					
10. Major current policies: Regulation, Competition					

MEDIATING ENVIRONMENT



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THREE MAJOR TYPES OF HEALTH POLICY ISSUES AND ANALYTICAL QUESTIONS FOR EACH POLICY ISSUE

	PUBLIC POLICIES	POLICY DEMANDS	POLICY DECISIONS	POLICY STATEMENTS	POLICY OUTPUTS	POLICY OUTCOMES
1. Policy Entry Issue						
1.1 Accessibility						
1.1.1 Economic						
1.1.2 Organizational						
1.2 Medical Costs						
1.3 Geographic Maldistribution						
2. Policy Service Issues						
2.1 Health Manpower						
2.2 Primary Care Services						
2.3 Quality of Care						
3. Policy Monitoring Issues						
3.1 Government Regulation						
3.2 Consumer Participation in Monitoring						

BIBLIOGRAPHY

Alford, Robert, Health Care Politics, Chicago, The University of Chicago Press, 1975, 295p.

Anderson, Odin, "Influence of Social and Economic Research on Public Policy in the Health Field," in John McKinlay, ed., Politics and Law in Health Care Policy, New York, Prodist, 1973, p.45-82

Bell, Daniel, The End of Ideology, Glencoe, Ill., Free Press, 1960, 416p.

Brown, Lawrence, The Formulation of Federal Health Care Policy, Washington, D.C., Brookings Institute, 1978

Brown, Lawrence, "Washington Report," Journal of Health Politics, Policy and Law, Winter 1982, p.822-826

Bice, Thomas W., "Social Science and Health Services Research: Contribution to Public Policy," Health and Society, Vol. 58, No.1, 1980, p.50-53

Burns, James MacGregor, The Deadlock of Democracy, Englewood Cliffs, N.J., Prentice Hall, 1963, 308p.

Dahl, Robert, Who Governs?, New Haven, Yale University Press, 1961, 355p.

Donovan, John, The Policy Makers, New York, Pegasus, 1970, 255p.

Pein R., "Social and Economic Attitudes Shaping American Health Policy," Milbank Memorial Fund Quarterly, Summer 1980, Vol.58, No.3, p.349-85

Fuchs, Victor, "Economics, Health and Post-Industrial Society," Health and Society, 1979, Vol 57, No.2, p.153-82

Kaufman, Herbert, "The Political Ingredient of Public Health Service, A Neglected Area of Research," in John B. McKinlay, ed., Politics in Law and Health Care Policy, New York, Prodist, 1973, p.23-43

Mechanic, David, " Some Dilemmas in Health Care Policy," Health and Society, 1981, Vol. 59, No.4, p. 1-15

Mills, C. Wright, The Power Elite, New York, Oxford University Press, 1959, 423p.

Renaud, Marc, "On the Structural Constraints to State Intervention in Health," in John Ehrenreich, The Cultural Crisis of Modern Medicine, New York, Monthly Review Press, 1978, p.101-119

Stevens, William K., "High Medical Cost Under Attack as Drain on the Nation's Economy," The New York Times, March 28, 1982, p.1+

Toffler, Alvin, The Third Wave, New York, Morrow, 1980, 544p.

U.S. Surgeon General, Work in America, Report of a Special Task Force to Secretary of Health, Education, and Welfare, Feb. 1973, Washington, D.C., Subcommittee on Employment, Manpower and Poverty, Feb. 1973

Vladeck, Bruce C., "The Design of Failure: Health Policy and the Structure of Federalism," Journal of Health Politics, Policy and Law, Fall 1979, Vol.4, No.3, p.522-35